Woburn & North Andover
pediatric associates & psychological services

Woburn Pediatric Psychological Services
7 Alfred Street – 2nd Floor, Woburn, MA 01801
Tel: 781-569-6022 / Fax: 781-281-1435

Behavioral Health Consent to Treat

NAME: _____

D.O.B.: _____

I have received a complete orientation packet, including material regarding confidentiality, rights, and responsibilities.

I agree to participate or give my permission for my child to participate in treatment.

I give permission to my or my child's psychiatrist/therapist to exchange relevant information with my primary care provider.

I give permission to my or my child's psychiatrist/therapist to share relevant information about my diagnosis and/or treatment as is required by the HIPAA Privacy Rule.

I authorize the release of information to any payer source necessary to process any claims for service to me by clinicians employed by Woburn Pediatric Psychological Services.

I have had the opportunity to fully discuss the above information with a behavioral health clinician and have an informed understanding of the elements of this authorization.

I have the right to revoke (cancel) this consent at any time except to the extent that my providers have already disclosed information in reliance of this form. If I do not take any action to revoke this consent, it will automatically expire upon termination of my participation in treatment at Woburn Pediatric Psychological Services.

In the event of an emergency, I will call 911 or go to the nearest emergency room. It is understood that 24-hour emergency coverage at Woburn Pediatric Psychological Services may not be possible and I am responsible for securing help for myself or my child.

I understand that my signature is not a condition of eligibility for or a requirement for receipt of benefits.

_____ _____
Signature of Parent/Guardian or Patient if over 18 years Date

_____ _____
Printed Name of Parent/Guardian or Patient if over 18 years Authority/relationship if not patient

EMAIL ADDRESS:_____